STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155557	A. BUILDING _____ B. WING _____	C 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	1651 N CAMPBELL ST INDIANAPOLIS, IN 46218

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

This visit was for the Investigation of Complaints IN00212154 and IN00211621.

This visit was in conjunction with the Recertification and State Licensure Survey. This visit included the Investigations of Complaints IN00205931 and IN00210874.

Complaint IN00212154 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00211621 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00205931 - Substantiated. No deficiencies related to the allegations are cited.

Complaint IN00210874 - Substantiated. No deficiencies related to the allegations are cited.

Survey dates: October 11, 12, 13, 14, 17, and 18, 2016.

Facility number: 000500
Provider number: 155557
AIM number: 100266220

Census bed type:
SNF: 14
SNF/NF: 46
Total: 60

Census payor type:
Medicare: 18
Medicaid: 39
Other: 3

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155557	A. BUILDING _____ B. WING _____	C 10/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLER'S MERRY MANOR	**1651 N CAMPBELL ST INDIANAPOLIS, IN 46218**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Total: 60 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quaity review completed by 30576 on October 20, 2016	F 000		